PHOTO IMAGE RELEASE FORM

Patient Name:_____

(Please Print)

Photo Description: _____ Employee Initials: _____

By signing this release form you *(the patient)* give Gulf Cove Dental the permission and consent to use your name and photograph *(taken before and after your treatment)* for advertising and/or publicity purposes in all forms of law abiding media that Gulf Cove Dental uses to promote its brand. You also acknowledge that you are doing this willingly and not under compulsion.

Release of Liability and Waiver

I hereby grant [Gulf Cove Dental] the absolute and irrevocable right to take, use, and publish before-and-after photographs of my dental treatment for educational, marketing, and promotional purposes, including print materials and digital media. I understand and agree that these photos may reveal my identity. I waive any right to inspect or approve the finished product or marketing copy that may be used. I acknowledge that I will receive no financial compensation for the use of these images. I hereby release, discharge, and agree to hold harmless [Gulf Cove Dental], its staff, and legal representatives from any and all liability, claims, or demands arising out of the use of these photographs, including any claims for defamation or invasion of privacy.

HIPAA Privacy Authorization for Use and Disclosure of Patient Photographs

1. Authorization and Description of PHI: I hereby authorize [Gulf Cove Dental] ("Practice") to use and disclose my individually identifiable health information, specifically consisting of clinical before-and-after photographs, video recordings, digital dental images, and/or related treatment descriptions showing my face, teeth, and mouth.

2. Purpose of Disclosure:This information is being disclosed for the purpose of practice marketing, educational presentations, public relations, and promotional materials. This includes, but is not limited to, the Practice's website, official social media accounts, print advertisements, patient brochures, and in-office portfolios. 3. Right to Revoke:I understand that I have the right to revoke this authorization at any time. My revocation must be submitted in writing to the Practice's Privacy Officer. I understand that a revocation is not effective to the extent that the Practice has already taken action in reliance on this authorization (such as materials already printed or published online).

4. Condition of Treatment:I understand that the Practice cannot and will not condition my dental treatment, payment, enrollment, or eligibility for health benefits on whether I sign this authorization. Refusing to sign will not affect the quality of clinical care I receive.

5. Potential for Re-disclosure:I understand that once my health information is disclosed publicly via marketing or social media channels, it may be subject to re-disclosure by the public and may no longer be protected by federal or state privacy regulations.

6. Expiration:This authorization shall remain valid for a period of ten (10) years from the date of signature, or until the date I revoke it in writing, whichever occurs first.

Patient's Signature: _____ Date: _____

(Parent or Guardian Signature if patient is a minor) : _____ Date:_____